STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445328	A. BUILDING _____ B. WING _____	05/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORT SANDERS TCU	1901 CLINCH AVE KNOXVILLE, TN 37916

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to apply device to prevent blood clots as order by the physician to one (#5) of nine residents reviewed. The findings included: Resident #5 was admitted to the facility on May 18, 2011, with diagnoses including Upper Gastrointestinal Bleed, Hypovolemia, and Anemia (Iron Deficiency and Blood Loss). Medical Record review of the admitting orders dated May 18, 2011, revealed an order for "Thromboguard" and a hand written order for "Thigh High while in bed." (Thromboguards are intermittent compression devices applied to the legs to prevent blood clots.) Observation on May 22, 2011, at 10:00 a.m., 1:20 p.m., and at 3:10 p.m., revealed resident #5 lying flat in bed in no acute distress. Observation revealed the Thromboguard device was not in the resident room. Interview in the resident room on May 22, 2011, at 3:10 p.m., with the nurse assigned the care of resident #5 (Registered Nurse RN #1) verified the devices were not in the room and thus not applied to the resident.	F 281	On 5/22/11 thromboguards were obtained and placed on the resident while in bed as ordered. This treatment was added to the treatment record (TAR). The Physician was notified of delay in putting thromboguards in place. Medical record reviews were conducted on 100% of residents to ensure all residents with treatment orders including thromboguards had received them and were in use according to the physician orders. Nursing staff will be reeducated regarding following physician orders and the process for ordering thromboguards. 30 medical records will be audited per month x 3 months to ensure all medical equipment is ordered appropriately and being used per physician orders. Then 30 medical records will be audited quarterly x 3 quarters. The findings will be presented to the Quality Improvement committee monthly then quarterly by Director of Nursing.	5/22/2011 5/30/2011 6/15/2011 ONGOING

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281	Continued From page 1 Interview with the Nurse Manager on May 24, 2011, at 8:10 a.m., in the conference room, confirmed the facility failed to apply the device as ordered.	F 281		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy, and interview, the facility failed to ensure the admission orders were dated and timed by the physician for two (#4 and #5) of nine records reviewed. The findings included: Resident #4 was admitted to the facility on May 13, 2011, with diagnoses including Lower Gastrointestinal Bleed, and Dementia with Delirium.	F 514	Attending physicians for resident #4 and #5 will be sent a letter regarding the policy on dating and timing of the orders. Also all physicians will be reeducated to the policy HIM.MR.010 "Physician Orders Transcription" regarding orders being dated and timed through the Friday Fax which is a newsletter for physicians The case manager will review all admission orders and if not dated and timed then admission orders will not be accepted and the attending physician will be contacted. 30 random medical records will be audited to ensure that the admission orders are dated and timed as per policy. Then 30 medical records will be audited quarterly x 3 quarters. The findings will be presented to the Quality Improvement committee monthly then quarterly by Director of Nursing.	6/30/2011 ONGOING ONGOING

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F 514	Continued From page 2 Medical record review of the facility's standing Admission Orders and Progress Notes revealed at the bottom of each sheet is written "Physician Signature, Date, and Time" each followed by a line to be completed by the prescribing physician. Medical Record review revealed the admission orders for resident #4 were not dated or timed by the physician. Resident #5 was admitted to the facility on May 18, 2011, with diagnoses including Upper Gastrointestinal Bleed, Hypovolemia, and Anemia (Iron Deficiency and Blood Loss). Medical Record review revealed the admission orders for resident #5 were not dated or timed by the physician. Review of the facility policy number HIM.MR.010 titled Physician Orders Transcription revealed, "Diagnostic and therapeutic orders shall be written legibly in ink or typewritten and shall be dated, timed, and signed." Interview with the Director of the facility at the nurses' station on May 22, 2011, confirmed the facility failed to ensure the medical records were completed by the physicians.	F 514		